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## Monitoring child health: school doctors at work in a Dutch rural area (1930–1970)

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### ABSTRACT

From 1948 the World Health Organization expected child hygiene to include mental health. This article discusses the way school doctors adapted their activities and concerns accordingly in the mid-twentieth century in an agrarian-industrial area of the Netherlands. In spite of an improvement in pupils' physical health they shifted their attention only to a limited extent towards mental health. Nevertheless, it became an important aspect of their work, as they stimulated activities they conceived of as promoting both physical and mental health, such as gymnastics and swimming. Their key interest concerned mental deficiency and the promotion of special schooling. In this respect they played a very active role, to the extent of producing 'feeble-mindedness' and learning disabilities. At the same time the school doctors clung to their traditional ideal of supporting the school's effectiveness by trying to reduce possible dangers threatening pupils' learning capacity and, increasingly, their mental well-being.

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### Introduction

During the mid-twentieth century across the West child hygiene seems to have widened its focus from physical health to also include mental health. This was probably stimulated by the World Health Organization (WHO), which started to promote a new, positive concept of health from 1948. It was no longer to be conceived as 'the absence of disease or infirmity' but as 'a state of complete physical, mental and social well-being.' Child health was now conceived in 'socio-psychosomatic' terms, implying that children were seen as part of their social environment and that mental health would be an equally important goal as physical health to be reached by child hygiene professionals. These positive and comprehensive goals, which fitted the developing welfare state, were at the heart of the 1951 *Technical Report* of the WHO's Expert Committee on School Health Services.<sup>1</sup> From that time school medical inspection was supposed to promote child health and well-being in the widest possible sense.

To date this widening task of school doctors has not received scholarly attention. Research into the history of school medical services has largely focused either on their introduction or on the development of the institution and its interaction with education. This is true both for studies that conceive of these services as a welfare provision aiming at and contributing

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<sup>1</sup>World Health Organization Expert Committee on School Health Services, *World Health Organization Technical Report Series no. 30* (Geneva: WHO, 1951).

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to the improvement of child health,<sup>2</sup> and for studies that refer to Michel Foucault's work on the history of social medicine and the role of the state in promoting hygienic control and approach their subject from the perspective of medical surveillance, hygienic disciplining, and classification and normalisation of childhood.<sup>3</sup> Although research into the history of child hygiene from a general perspective has pointed at the increasing importance of mental health,<sup>4</sup> this has not yet inspired inquiries into the particularities of school doctors' activities.

It is likely that school doctors have enlarged their working area to include aspects of mental health. This is suggested by studies into the history of psychology and the way it has come to shape people's identity and popular images of health. From a control-oriented perspective the British sociologist Nikolas Rose claims, for example, that the first decades of the twentieth century in England witnessed the rise of psychology as an applied discipline governing people, including children, through state-supported institutions meant to promote health and welfare, such as child guidance clinics for emotionally disturbed children.<sup>5</sup> Also, Mathew Thomson's cultural history of British psychology points at the interwar years as decisive in terms of establishing a way of viewing ourselves and our world in psychological terms. As regards schoolchildren he mentions testing and child guidance as increasingly important professional psychological practices.<sup>6</sup> We may assume that a large proportion of their clients were first seen or were referred by a school doctor.

The available studies of the history of child hygiene in the twentieth century make clear that school doctors played a key role in this respect. Across the West their assignments included the prevention of the spread of contagious diseases, vaccination and periodic health examinations of pupils and teachers, the promotion of hygienic school buildings and furniture, the prevention of health-threatening time schedules, and the dissemination of hygienic knowledge among teachers, parents and pupils. Whereas in some countries, like England and Wales,<sup>7</sup> school doctors could also treat a child's ailments, in other countries, like the Netherlands,<sup>8</sup> their assignment was strictly limited to prevention and, consequently, to referring a child to a general practitioner for treatment. Everywhere, school doctors were expected to identify health problems of individual children, such as defective vision and hardness of hearing, as early as possible to prevent learning problems. In doing so, they contributed to the quality and effectiveness of teaching. When special provisions were available, 'feeble-minded' children had to be referred to special schools and 'pretuberculous' children to open air schools and health camps.<sup>9</sup> Although the establishment of child guidance clinics

<sup>2</sup>Bernard Harris, *The Health of the Schoolchild: A History of the School Medical Service in England and Wales* (Buckingham: Open University Press, 1995); Fedor de Beer, *Witte jassen in de school. De schoolarts in Nederland ca. 1895–1965* (Assen: Van Gorcum, 2008).

<sup>3</sup>Harry Hendrick, 'Child Labour, Medical Capital, and the School Medical Service, c. 1890–1918', in *In the Name of the Child: Health and Welfare 1880–1940*, ed. Roger Cooter (London: Routledge, 1992), 45–71; Mona Gleason, 'Race, Class, and Health: School Medical Inspection and "Healthy" Children in British Columbia, 1890 to 1930', *Canadian Bulletin of Medical History* 19 (2002): 95–112.

<sup>4</sup>Marijke Gijswijt-Hofstra and Hilary Marland, eds., *Cultures of Child Health in Britain and the Netherlands in the Twentieth Century* (Amsterdam/New York: Rodopi, 2003).

<sup>5</sup>Nikolas Rose, *The Psychological Complex: Psychology, Politics, and Society in England, 1869–1939* (London: Routledge & Kegan Paul, 1985).

<sup>6</sup>Mathew Thomson, *Psychological Subjects: Identity, Culture, and Health in Twentieth-century Britain* (Oxford/New York: Oxford University Press, 2006).

<sup>7</sup>Harris, *Health*.

<sup>8</sup>De Beer, *Witte jassen*.

<sup>9</sup>Harris, *Health*; De Beer, *Witte jassen*; Nelleke Bakker, 'Sunshine as Medicine: Health Colonies and the Medicalization of Childhood in the Netherlands, c.1900–1960', *History of Education* 36 (2007): 659–79.

made mental health an increasingly important issue in education,<sup>10</sup> it is not discussed in studies in the history of school medical inspection.

As it turns out, little is known about school doctors' daily activities and concerns. This is especially true for countries like the Netherlands that did not introduce legislation in which school doctors' assignment was set on a national level, as happened in many European countries, including England and Wales. In countries without such legislation local and regional authorities could create their own models of school hygienic control. In the Netherlands this was the case up to 1990. Which were the assignments of school medical services in that country? On which ailments did school doctors focus in their periodic health examinations of pupils and hygienic inspections of buildings and furniture and what were their findings? Which changes can be seen in the attention they paid to aspects of physical and mental health during the period of transition from a purely physically oriented school medical service to the post-war years when mental health was supposed to be included, between about 1930 and 1970? To what extent did their activities reflect the national discourse on child hygiene rather than the availability of provisions like a child guidance clinic or a special school in their working area? And did school doctors themselves play an active role in stimulating the creation of special provisions for less healthy or disabled children? This interaction between the focus and activities of school medical services and their national and local environment can best be studied for those communities where these provisions were not self-evident and did not arrive early or as an immediate reaction to shifts of interest among scientists or in national politics, as was the case in the larger cities.<sup>11</sup>

To find out what monitoring child health amounted to on a day-to-day basis, the focus of this article is the activities and concerns of school doctors during the period of transition in a relatively backward and sparsely populated, agrarian-industrial area in the north-east of the Netherlands, the Province of Groningen.<sup>12</sup> Here, school medical services first became available in two countryside districts in 1930. Forty years later nine districts offered these services. Most of these were situated too far away from the provincial capital to be easily able to use city-based provisions like a child guidance clinic or a special school. The first two sections of this paper focus on the development between 1930 and 1970 of school medical services and mental health care for children in the Netherlands in general and in the Province of Groningen in particular. The next two sections consider the activities and concerns of the school doctors of this province as regards children's physical and mental health respectively to find out if, when and how these countryside districts conformed to the WHO's prescript of monitoring the child's health and well-being in the widest possible sense. The annual reports and the archive of the district school doctors are used as sources to reconstruct and evaluate their activities and understand their shifting concerns.<sup>13</sup>

<sup>10</sup>Deborah Thom, 'Wishes, Anxieties, Play, and Gestures: Child Guidance in Inter-war England', in Cooter, *In the Name of the Child*, 200–19; Nelleke Bakker, 'Child Guidance and Mental Health in the Netherlands', *Paedagogica Historica* 42 (2006): 769–91; Sol Cohen, *Challenging Orthodoxies: Toward a New Cultural History of Education* (New York: Peter Lang, 1999), Part II.

<sup>11</sup>De Beer, *Wittejassen*, 77–81; T. van der Grinten, *De vorming van de ambulante geestelijke gezondheidszorg. Een historisch beleidsonderzoek* (Baarn: Ambo, 1987).

<sup>12</sup>H. J. ter Bogt and H. Copinga, *Van agrarisch gewest naar moderne regio. 50 jaar ETI-Groningen* (Groningen: ETI, 1987).

<sup>13</sup>The availability of the complete series of these reports for the years 1930–1970 is unique. Therefore, a comparison of the Groningen countryside data is possible only with the national data collected by the national Inspector of Child Hygiene (see note 17). They concern only the years 1948–1955. Besides the annual reports, the complete archive of the Provincial School Medical Service of Groningen is available, which is equally unique.

## School medical services in the Netherlands and in the Province of Groningen

As elsewhere in the West, school medical services were established in Dutch cities from the turn of the twentieth century, particularly from 1904, and they continued to spread across the countryside up to the mid-1960s, when they finally covered the country as a whole. The City of Groningen first appointed a school doctor in 1908.<sup>14</sup> In 1929, 48% of all Dutch primary pupils were under hygienic supervision, mostly in cities. Private religious schools were free to use or not use the service, whereas public schools participated automatically. The service was free for all schools and if a school participated parents were free to refuse to have their child examined.<sup>15</sup>

The first countryside district school doctors were appointed in 1927 in a very poor and backward peat area in the Province of Drenthe, just south of Groningen.<sup>16</sup> This inspired the Province of Groningen to support local communities to form 'groups' that could appoint a school doctor collectively.<sup>17</sup> The first two were appointed in 1930,<sup>18</sup> a third in 1932, and a fourth in 1933.<sup>19</sup> This made the province a champion of district services. In 1936 it counted four out of a total of 12 district services available in the country as a whole within its borders.<sup>20</sup>

In 1942, during the German occupation, all municipalities were obliged to appoint school doctors. After the war the Dutch government continued to subsidise the creation of school medical services. As a result the number of participating municipalities grew from 596 in 1943 to 812 in 1947, covering 80% of the country. Full coverage was reached in 1965, when the last municipality joined a district service.<sup>21</sup> In the Province of Groningen this point had been reached earlier, in 1943, when all 65 municipalities participated in a district service.<sup>22</sup> Because schools were not obliged to make use of the service this does not imply that all children were monitored by a school doctor but the larger percentage were, as the acceptance of the service was high, even among religious parents who used to be afraid of state regulation of their private, religious schools. School doctors in the Province of Groningen continued to emphasise, particularly from the 1940s, that their service covered all or almost all schools in their district.<sup>23</sup>

In terms of numbers of schools and pupils under hygienic supervision the post-war years in particular show a huge increase. The development in the Province of Groningen is shown in Table 1. The slight reduction in the number of schools and pupils supervised by

<sup>14</sup>De Beer, *Witte jassen*, 64–92.

<sup>15</sup>Nelleke Bakker and Fedor de Beer, 'The Dangers of Schooling: The Introduction of School Medical Inspection in the Netherlands (c.1900)', *History of Education* 38 (2009): 505–24.

<sup>16</sup>De Beer, *Witte jassen*, 79–81.

<sup>17</sup>Archive of the School Doctors Service of the Province of Groningen (*Schoolartsdienst Provincie Groningen*, SPG), Groningen Archives (GA) no. 1236: I, 2.

<sup>18</sup>*Verslag van den Schoolartsdienst in de groep Hoogezand, over het tijdvak 1 juni–31 December 1930* (no place of publication, n.d.); *Verslag van den Schoolartsdienst in de groep Veendam, over het tijdvak 1 juni–31 December 1930* (no place of publication, n.d.).

<sup>19</sup>*Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam en Winschoten over het jaar 1934* (Sappemeer: Kleefsman, n.d.).

<sup>20</sup>De Beer, *Witte jassen*, 80.

<sup>21</sup>*Ibid.*, 80–92.

<sup>22</sup>*Verslag van den Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1943* (Groningen: Hoitsema, n.d.).

<sup>23</sup>Minutes of the meetings of the committees for the provincial school medical services: SPG, GA no. 1236: II, 1–12.

**Table 1.** Schools and pupils in the Province of Groningen\* under medical supervision.<sup>a</sup>

Year	Districts	Schools	Pupils
1930	2	58	–
1940	3	151	16,706
1950	7	607	51,389
1960	9	696	66,948
1970	9	652	64,884

\*Excluding the City of Groningen.

<sup>a</sup>*Verslag Hoogezand 1930* (see note 18); *Verslag Veendam 1930* (see note 18); *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand en Veendam over het jaar 1940* (Groningen: Hoitsema, n.d.); *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1950* (Groningen: Hoitsema, n.d.); *Verslag van de Schoolartsdienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1960* (no place of publication, n.d.); *Verslag van de Schoolartsdienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winsum, Winschoten en Zuidhorn over het jaar 1970* (no place of publication, n.d.).

a school doctor in the 1960s is due to a stagnating birth rate and to depopulation of parts of the countryside.<sup>24</sup>

Each year between half and one-third of the pupils at the supervised schools were subjected to a full medical check-up, the periodic health examination. This concerned all pupils of the first grades (aged 6–7), all pupils of the final grades (aged 11–13), and the pupils of one of the grades in between, making sure that every pupil was fully examined three times. A small number of pupils were, moreover, examined more specifically because the teacher suspected them of suffering from a particular disease. With time, especially after the war, the pupils examined became more diverse, as infant and secondary schools joined the services, whereas the numbers of children attending these kinds of schools multiplied quickly. From the 1950s, as a rule a child was fully examined five times during her/his school career: once in infant school, three times in primary school and once more in one of the secondary schools in the Groningen countryside.

As Dutch school medical services did not have a legal basis, school doctors were free to report on their work in their own way. For the researcher this has the uneasy consequence of non-comparable data. This is compensated for by the fact that employers of a number of school doctors, in big cities or provinces, expected their staff to provide information on particular issues. The same is true of the national Inspector of Child Hygiene, who from 1948 required information on a list of items to be given by the school doctors in their annual reports. The national results were published between 1952 and 1958. They concern the years 1948–1955 (see Table 2). Nevertheless, school doctors continued to report in different ways. With time, however, their reports become not only more homogeneous but also more detailed as regard children's 'abnormalities'. From the late 1940s, as to children's eyes for example, all provincial school doctors added numbers of children suffering from squint and colour-blindness, whereas from the 1960s they started to differentiate between weak-sighted children who already wore glasses and 'newly found' cases. Around 1960 vaccination levels and referrals to special care like remedial gymnastics or speech lessons became more important in the doctors' annual reports than the numbers of abnormalities found, a shift of focus that followed the reports of the national Inspector of Child Hygiene

<sup>24</sup>Ter Bogt and Copinga, *Van agrarisch gewest*; Kees Schuyt and Ed Taverne, *1950: Prosperity and Welfare* (Assen: Van Gorcum, 2004).



**Table 2.** Average percentages of pupils fully examined by the district school doctors of the Province of Groningen\* found to be in insufficient feeding/physical condition and with abnormalities.<sup>a</sup>

Year and total number of districts	Total number of fully examined pupils	% of pupils in (very) insufficient feeding/physical condition	% of pupils aged 6–7 in (very) insufficient feeding/physical condition	% of pupils with abnormalities
1930: 2	2125	–	14.0 (2)	45.6
1935: 4	7850	28.7	15.7 (3)	–
1940: 3	7651	–	–	–
1945: 6	12,222	8.3 (3)	–	58.0 (3)
1950: 7	28,032	14.2 (1) – 5.0 n	–	63.7 (2) – 62.2 n
1955: 7	28,163	8.4 (5) – 4.3 n	–	67.7 (2) – 62.9 n
1960: 9	28,108	3.8	–	60.3 (6)
1965: 9	27,187	2.7	–	49.2 (5)
1970: 9	23,189	0.5 (4)	–	46.6 (2)

\*Excluding the City of Groningen.

Notes: Figures in parentheses indicate number of districts providing information on this item (if lower than total); n = national average.

<sup>a</sup>*Verslag Hoogezand 1930; Verslag Veendam 1930; Verslag van den Schoolartsendienst in de groepen Appingedam, Hoogezand, Veendam en Winschoten over het jaar 1935* (Sappemeer: Kleefsman, n.d.); *Verslag van de Schoolartsendienst in de groepen Appingedam, Hoogezand, Vlagtwedde, Winschoten, Winsum en Zuidhorn over de jaren 1945 en 1946* (Groningen: Hoitsemma, n.d.); *Verslag 1950; Verslag van de Schoolartsendienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1955* (no place of publication, n.d.); *Verslag 1960; Verslag van de Schoolartsendienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1965* (no place of publication, n.d.); *Verslag 1970; VMbV 1954, 484–5; VMbV 1958, 104–5*. For abbreviated titles see Table 1.

who had stopped collecting numbers of schoolchildren's abnormalities in the late 1950s.<sup>25</sup> In spite of growing criticism as to its use, Groningen school doctors continued to collect these numbers until 1971.<sup>26</sup>

The periodic health examination itself developed, moreover, from a relatively simple check-up of a child's basic functions (eyes, ears, throat, teeth, posture, spine, skin, hair and feeding condition) in the 1930s to a much more extensive examination focusing particularly on abnormalities as regard the functioning of all senses and organs, including the central nervous system, in the 1960s. In 1960 the school doctors of the Province of Groningen reported on an average number of 23 aspects of child health, from 'general physical condition' and 'eyes' to referrals to the general practitioner, more than twice as many aspects as had been covered in 1940.<sup>27</sup>

## Mental health care for children in the Netherlands and in the Province of Groningen

The first Dutch child guidance clinic was established in Amsterdam in 1928 and it was modelled after the American example, leaning heavily on a mix of psychoanalysis and individual psychology as theory. Treatment was provided by a multi-disciplinary team, led by a psychiatrist.<sup>28</sup> Their number of these clinics started to grow substantially after the war. Between 1947 and 1952 it increased from eight to 15, and in the next decade even to

<sup>25</sup>*Verslagen en Mededelingen betreffende de Volksgezondheid (VMbV) 1952–8*. The report on 1959 (issued in 1962) was the first that left out these numbers.

<sup>26</sup>Minutes SPG, GA no. 1236: II, 8–12.

<sup>27</sup>*Verslag 1940* (see Table 1); *Verslag 1960* (see Table 1).

<sup>28</sup>Bakker, 'Child Guidance'.



45, next to thirty separate but comparable Roman Catholic clinics.<sup>29</sup> In the post-war years a 'moral crisis' was generally perceived in Dutch society. Rising numbers of divorces and illegitimate births in the immediate aftermath of the war had given cause to this anxiety. In this socio-cultural climate mental health became a key issue in welfare politics. Children embodied the nation's future, it was claimed. Primary prevention of mental ill-health, therefore, ought to begin early. That is why, apart from the child guidance clinics, the development of infant and toddler health bureaus was strongly supported in this period.<sup>30</sup> From the late 1940s child psychiatric expertise also became available in newly created youth departments of provincial social psychiatric services, Youth Psychiatric Services, which likewise developed as part of the post-war 'crusade' against mental ill-health.<sup>31</sup>

In the City of Groningen a child guidance clinic was not established before 1960. The professor of paediatrics at the University of Groningen, Gabbe Scheltema, however, had established a bureau for parents and children with 'child-rearing problems' in 1928. After the war it continued to provide parenting support, but it focused more particularly on toddlers and their parents, before it was integrated into a toddler health bureau. In 1956 support was given once a week at four different places in the province.<sup>32</sup> As the need for psychiatric treatment of children of all ages was felt more urgently after the war and child psychiatry was lifted to academic status in the early 1950s, it is not surprising that mental health experts have successfully pressed for the establishment of a real child guidance clinic. Next to treating children with emotional problems, the clinic acted as a training ground for child psychiatrists and psychiatric social workers, as well as as a centre of expertise and examination for all kinds of institutions providing youth welfare and protection services.<sup>33</sup> As before, only very serious cases were referred to the university child-psychiatric clinic.

The earliest referrals of children to the Youth Psychiatric Service by school doctors in the Province of Groningen date from 1947.<sup>34</sup> The province was one of the pioneers in providing specialist social psychiatric help to children and in setting up a Youth Department within this service. It was argued that the targeted children had the same social background as the adult clientele and that they often came from the same, lower-class families.<sup>35</sup> Referrals of children to this provincial service continued after the child guidance clinic had opened up, throughout the 1960s. The Youth Department of the service seems to have acted as a more practical alternative for the time-consuming, multi-disciplinary approach of the clinic and especially for its psychoanalytical 'talking' cure, from which 'mentally deficient' children were excluded and which did not fit the profile of the poorly educated countryside parents. The Youth Psychiatric Service provided testing of all sorts to diagnose mentally 'disturbed' or deficient children. As a rule school doctors limited themselves to the use of the Binet-Herderschêe intelligence test<sup>36</sup> and referred to the Service only in cases of emotional trouble or doubt as to the test results.

<sup>29</sup>Van der Grinten, *De vorming*, 186–209.

<sup>30</sup>*Ibid.*, 186–209; Bakker, 'Child Guidance'; VMbV 1952–8.

<sup>31</sup>T.B. Kraft, *De jeugdpsychiatrische diensten in Nederland* (Utrecht: Bijleveld, 1962), 139–152; Bakker, 'Child Guidance'.

<sup>32</sup>M. Brandenburg, 'De Bureaus voor opvoedingsmoeilijkheden', *Maandblad voor de Geestelijke Volksgezondheid* 11 (1956): 173–8.

<sup>33</sup>Bakker, 'Child Guidance'; Kraft, *De jeugdpsychiatrische diensten*, 10.

<sup>34</sup>*Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1947* (Groningen: Hoitsema, n.d.), 64.

<sup>35</sup>Kraft, *De jeugdpsychiatrische diensten*, 140.

<sup>36</sup>De Beer, *Witte jassen*, 248–64.

In the Netherlands special day schools for feeble-minded children, with relatively small groups, mainly developed after 1920, when a new School Act recognised special education, implying financial support from the government. In 1930 there were 90 day schools for feeble-minded children in the country as a whole. The City of Groningen could avail of a school for feeble-minded children from 1915,<sup>37</sup> and of a second one from 1934.<sup>38</sup> The countryside of the province had to do without such schools for a relatively long time. The majority of the district centres had to wait until the early 1950s.<sup>39</sup>

A new kind of special school, for children with specific learning and behavioural problems (*'leer- en opvoedingsmoeilijkheden'*, LOM) but a normal IQ, introduced from 1949, did not reach the countryside of the Province of Groningen until the mid-1960s. In 1965 the first LOM school was established in Winschoten, the same town in the eastern part of the province that had pioneered in special schooling for feeble-minded children in 1939.<sup>40</sup> With 7.9% of the primary pupils of the district attending one of its three special schools in 1970, this district stands out against both the other districts in the region and the national level of 4% of the children attending a special school for feeble-minded or learning-disabled children.<sup>41</sup> In the same year in the district of Veendam in the south of the province 5.7% of the primary pupils were taught in one of its three special schools: 3.3% at the two schools for feeble-minded children, as against 2.9% in the country as a whole, and 2.4% at the LOM-school (established in 1966),<sup>42</sup> as against 1.1% in the country as a whole. From the more detailed report of the school doctor of the latter district we learn that children with a very low IQ-score (below 50, the 'imbeciles') were taught separately from those with only a minor intellectual deficit, each group attending a small school of its own.<sup>43</sup> This separation between more or less feeble-minded children had developed in cities from the 1930s and had become national policy since the 1950s. These examples illustrate that the farther away from the City of Groningen, the more developed and differentiated special education in the countryside was. The distance, combined with the absence of railways in these parts of the province, prevented the use of facilities in the City of Groningen.

As regards school doctors' assignment and their responsibility for children's mental health, the national discourse soon adopted the WHO's new principle of the promotion of positive, comprehensive and inclusive health and well-being. This became particularly clear at a conference in 1952 on the future of school medical inspection. Scientists criticised school doctors' routines of searching for and registering abnormalities in children, unaware of whether or not these had already been identified by their parents or by a general practitioner. Their search, moreover, was carried out without the formulation of a positive health norm. Most serious, however, was the critique of school doctors' lack of interest and expertise in the field of mental health, whereas it was estimated that between two thirds

<sup>37</sup>*Gedenboek omtrent zorg voor en onderwijs aan zwakzinnigen*, ed. P.H. Schreuder, G.J. Vos, and D. Herderschêe ('s-Gravenhage: Haga, 1929), 216.

<sup>38</sup>*Statistiek van het buitengewoon lager onderwijs 1931–1934* ('s-Gravenhage: CBS, 1936), 15.

<sup>39</sup>*Statistiek van het buitengewoon lager onderwijs 1939–1947* ('s-Gravenhage: CBS, 1949), 7; *Statistiek van het buitengewoon lager onderwijs 1951/52 – 1954/55* (Utrecht: CBS, 1955), 13.

<sup>40</sup>*Verslag van de Schoolartsendienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1965* (no place of publication, n.d.), 71, 101.

<sup>41</sup>*Verslag 1970*, 85; Dorien Graas, *Zorgenkinderen op school. Geschiedenis van het speciaal onderwijs in Nederland, 1900–1950* (Leuven/Apeldoorn: Garant, 2008), 114.

<sup>42</sup>*Verslag van de Schoolartsendienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1967* (no place of publication, n.d.), 55.

<sup>43</sup>*Verslag 1970*, 49 (see Table 1); Graas, *Zorgenkinderen*, 114.

and three quarters of the abnormalities found related to mental health.<sup>44</sup> According to some critics mental health had become even more important after children's physical health had improved substantially during the immediate post-war years.<sup>45</sup>

School doctors themselves, however, were reluctant to let go of their routine examinations and to enter the field of child psychiatry, because they wanted to continue to play their role as social-hygienic experts. From 1962, according to their wishes, youth health care was recognised as a social-medical specialism, for which a special training was designed. Henceforth, 'youth physicians' practising in infant and toddler health bureaux or in school medical services were trained to become competent in each of the three fields that were included in the WHO's concept of health: children's biology, psychology and social environment.<sup>46</sup>

In the meantime, from the 1950s, next to the school medical services, independent school psychological services developed to provide for the testing and diagnosing of learning-disabled children, first of all in the cities. Compared to other Western countries this was relatively late and the assignment of the services was relatively narrow, as schoolchildren's mental health was already covered by the Youth Psychiatric Services and the child guidance clinics.<sup>47</sup> In 1963, 46 school psychological services had been established in the country as a whole.<sup>48</sup> The Province of Groningen first appointed a school psychologist in 1957. The new professional was expected to lighten the work load of the school doctors and the Youth Psychiatric Service by taking away the burden of testing the increasing number of children with learning disabilities.<sup>49</sup> The district school doctors became frequent users of the school psychological service for testing and advice on more specialised help.<sup>50</sup>

## Monitoring physical health

School doctors of the Groningen districts always reported on children's general physical condition. Before the war they referred to it as their 'feeding condition'. Most of the time they qualified a child's health as good, moderate, insufficient or very insufficient. In the post-war years the major improvement of schoolchildren's physical health stimulated so much discussion on the use of categories in these reports, that for a number of years no information at all was provided on the general physical condition of the Groningen schoolchildren, which explains the missing data for 1950 of all but one district in Table 2. This practice was resumed in 1952.

Table 2 presents the results of the periodic health examinations as regard the children's 'feeding condition' or 'general physical condition', particularly the percentage of children qualified as (very) insufficiently fed or found to be in a (very) insufficient condition, next to the percentage of children with whom abnormalities had been found. The majority of the pupils had a good or sufficient condition. This was even true of children of unemployed

<sup>44</sup>Nederlands Congres voor Schoolgeneeskunde, *Tijdschrift voor Sociale Geneeskunde* 31 (1953): 59–94, 109–130; A. Querido, 'Schoolgeneeskunde en volksgezondheid', *Tijdschrift voor Sociale Geneeskunde* 31 (1953): 73–9.

<sup>45</sup>J.T. Buma, *De sociale kinderhygiëne in Nederland. Haar organisatie en haar toekomst* (Assen: Van Gorcum & Comp., 1954).

<sup>46</sup>De Beer, *Witte jassen*, 120–2.

<sup>47</sup>Kraft, *De jeugdpsychiatrische diensten*, 21–2, 153–7; Thomson, *Psychological Subjects*.

<sup>48</sup>*Schoolpsychologie. Taak en organisatie* (Amsterdam: NIPP, 1964).

<sup>49</sup>Kraft, *De jeugdpsychiatrische diensten*, 140.

<sup>50</sup>*Verslag van de Schoolartsendienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1964* (no place of publication, n.d.), 62, 70.

**Table 3.** Average percentages of pupils fully examined by the district school doctors of the Province of Groningen\* found to have physical abnormalities, according to their nature.<sup>a</sup>

Year and total number of districts	Skin and hair	Unclean heads	Sight	Hearing	Teeth	Scoliosis	Rachitis	Posture
1930: 2	3.3	17.2	10.1	1.7 (1)	50.2 (1)	11.4	8.2 (1)	18.0 (1)
1935: 4	3.6	3.5	8.5	–	3.5 (1)	16.4 (2)	–	13.7 (2)
1940: 3	2.9	1.7	7.3	–	7.7 (1)	5.3	1.3 (1)	5.1 (1)
1945: 6	8.5	4.1 (4)	8.2	1.0	10.5 (2)	2.1 (5)	5.1 (3)	8.7 (4)
1950: 7	4.3	2.6 (5)	9.7 (6)	1.0 (5)	49.0 (3)	3.2 (5)	11.5 (3)	13.4
1955: 7	5.5 (6)	1.8 (6)	12.8	1.7 (6)	59.0	5.3 (6)	4.9 (6)	16.4
1960: 9	4.5	1.1	20.2	3.7	45.8	3.8 (4)	3.0 (4)	12.8
1965: 9	3.2	0.4 (8)	20.3	4.8 (8)	40.9	0.9 (5)	3.6 (2)	6.7
1970: 9	2.7 (7)	0.4 (4)	17.3	3.8	53.1 (4)	0.3 (4)	–	3.7 (8)

\*Excluding the City of Groningen.

Note: Figures in parentheses indicate number of districts providing information on this item (if lower than total).

<sup>a</sup>*Verslag Hoogezand 1930; Verslag Veendam 1930; Verslag 1935, Verslag 1940, Verslag 1945 en 1946, Verslag 1950, Verslag 1955, Verslag 1960, Verslag 1965; Verslag 1970.* For abbreviated titles see Tables 1 and 2.

fathers during the economic crisis of the 1930s.<sup>51</sup> Children with an insufficient condition, moreover, hardly ever got the qualification ‘very’ insufficient. The declining percentage of pupils with an unsatisfactory condition illustrates their improving physical health, particularly from the late 1950s, when the economy started to grow exponentially.<sup>52</sup> The low percentage of ill-fed children in 1945/46 shows that children living in the food-producing countryside of Groningen had not suffered from the ‘hunger winter’ during the last war year to the extent that city children in the western part of the country had.<sup>53</sup> The relatively high percentage of children with an insufficient condition during the next decade is likely to have been caused by high expectations of the school doctors, who expressed their concerns in the annual reports,<sup>54</sup> rather than by a deteriorating condition. The percentages of children found with abnormalities in the 1950s are remarkably similar to the national numbers. The discrepancy between the sharply decreasing level of physical health insufficiency in the 1960s and the consistently high level of children with abnormalities can best be explained by the many new health items included in the examination, such as flat feet, and the increasing availability of special care to which a child could be referred. The newly appointed professionals, such as remedial gymnastics teachers, needed properly selected clients.

The development of the percentages of abnormalities found by the Groningen school doctors for some items concerning physical health is shown in Table 3. Though the numbers of abnormalities found varied significantly between school doctors, especially before 1950, the data support an overall improvement of schoolchildren’s physical health. The decrease of the number of children suffering from rachitic deformation or rickets (except for 1950), caused by a lack of vitamin D, testifies in particular of the improving health condition of young children.

<sup>51</sup>*Verslag 1935*, 29 (see Table 2).

<sup>52</sup>Schuyt and Taverne, 1950.

<sup>53</sup>Samenvattend rapport over het onderzoek naar de voedingstoestand van Amsterdamse schoolkinderen – 1951; *Tijdschrift voor Sociale Geneeskunde* 29 (1952): 136–40.

<sup>54</sup>*Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1953* (no place of publication, n.d.); *Verslag van de Schoolartsdienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1958* (no place of publication, n.d.).

Contagious infections of the skin, such as scabies and eczema, and the head, such as favus, were rare during the 1930s, but increased after the war. This is probably related to the larger school classes of those years, which made pupils sit close to each other. The problem was reduced when classrooms became less crowded from the early 1960s. Unclean heads or lice ('living uncleanness') show a linear decrease, except for the final year of the war, when infections flourished. The improvement of the cleanliness of skin and hair from the late 1950s seems to be an outcome of the overall amelioration of hygienic conditions in the countryside, including water from the tap and more frequent bathing and swimming.<sup>55</sup> Countryside schools in Groningen were provided with water from the tap during the 1950s. In most cases the taps and water closets came with new, lighter and more spacious buildings. These were warmly welcomed by the school doctors, but not without comments. Schools either forgot or could not afford a few items they conceived of as indispensable: toilet paper, soap and paper towels. Their reports presented unwashed hands, a dirty towel and a collectively used drinking mug as possible sources of infection.<sup>56</sup>

The increase in the number of cases of reduced sight (Table 3) after the war is probably related to improved methods of testing and stricter norms as to the limits of 'adequate' sight. Other abnormalities of the eyes, like infections, and newly registered ones, like squint and colour-blindness, are not included in the numbers presented in Table 3. Unlike most other abnormalities, relatively many cases of reduced sight were discovered with secondary pupils. Therefore, the rapidly increasing participation in secondary education in the post-war years partly explains the growing number of pupils in need of glasses. When in the 1960s school doctors finally mentioned the proportion of weak-sighted children who already wore glasses, this turned out to be a majority. In other words, the time-consuming examination of the eyes of complete school classes was not very useful at a time when parents and teachers were keen enough to notice deficiencies of pupils' sight and Medicaid<sup>57</sup> provided for free glasses. Hearing deficiencies likewise increased among the Groningen pupils in the post-war years, but on a much lower level. This rising number seems to be a consequence of improved screening, as much more objective audiometers replaced the traditional whispering test.<sup>58</sup>

As to teeth, in the 1930s hardly any pupil had an intact set of teeth. In the post-war years school doctors evaluated the condition of children's teeth as good, moderate or bad. During the 1950s the percentage of 'moderate' or 'bad' teeth does not show the expected decrease (Table 3), but from 1960 it did. The exceptionally low percentage of 'good' teeth in 1955 is probably an effect of the appointment of school dentists in the previous years, amounting to a more extensive examination and more frequent treatment of schoolchildren's teeth. This illustrates that health deterioration could be 'produced' by increasing hygienic supervision and by extension of medical care. Another cause of the 'teeth crisis' in 1955 is probably the increase of the proportion of secondary pupils, with whom 'moderate' or 'bad' teeth were found relatively often. In the 1960s bad teeth finally became rare, whereas at the same time

<sup>55</sup>Henk van Setten, *In de schoot van het gezin. Opvoeding in Nederlandse gezinnen in de twintigste eeuw* (Nijmegen: SUN, 1987), 48–60.

<sup>56</sup>*Verslag 1953*, 5–8; *Verslag 1955*, 5–8; *Verslag 1958*, 5–6; *Verslag 1960*, 5–6.

<sup>57</sup>Medicaid was a state-supported medical insurance for people with a low income. Care provisions were usually free, like simple glasses and hearing aids.

<sup>58</sup>VMbV 1969, 65–7.

criteria became stricter.<sup>59</sup> In 1970 some doctors only mentioned the percentage of children under regular control of a dentist in their reports.

Periodical tuberculosis screening of all pupils was part of the school doctors' assignment from 1943, and it continued throughout the period of this research as part of a national programme, although adult and child tuberculosis mortality and morbidity rates decreased rapidly after the war.<sup>60</sup> In 1957 two thirds of the Dutch school doctors still tested all pupils annually.<sup>61</sup> The numbers of children reacting positively to the Von Pirquet or Mantoux blood tests had been low from the start, but approached zero during the 1960s. Children with a positive test result were referred to a specialised regional tuberculosis bureau to be x-rayed and in case of illness treated in a sanatorium. From the 1950s, the very few cases of tuberculosis that were found justify the conclusion that the time-consuming mass screening was not useful any more. The minutes of the committees that supervised the work of the Groningen school doctors show that a single case of an infected child could silence for years the critique of the mass screening of pupils, first expressed in 1948, as a time-consuming and unproductive practice.<sup>62</sup>

School desks and long hours of sitting still at ill-fitting desks have a history of being blamed for causing deformities of pupils' spines. These problems are often considered to have been solved by the time school doctors started their work.<sup>63</sup> In the Province of Groningen, however, school furniture continued to be the object of school doctors' complaints until the early 1960s. During the economic crisis of the 1930s financial cuts caused one of the district school doctors to advise the local authorities to at least buy new furniture for children diagnosed with scoliosis.<sup>64</sup> Post-war prosperity did not immediately bring about a solution, although the numbers of victims of scoliosis decreased rapidly (Table 3). Throughout the 1950s the Groningen school doctors frequently complained that pupils sized above or below the average of an age group had to use non-fitting desks. One size did not fit all. Schools had to buy their furniture in more varying sizes and take extra desks in reserve because children grow in spurts, the doctors insisted. Although experts had already advised the government on the use of sets of individual chairs and tables in 1953,<sup>65</sup> these were not introduced in the province before the early 1960s.

Remedial gymnastics for children with posture problems were advised from the 1930s. It may not be a surprise that school doctors were pleased when the occupying German authority did not hesitate in 1940 to suspend the possibility for schools to escape the obligation to teach gymnastics for reasons of not having a gymnasium.<sup>66</sup> Apart from increased knowledge regarding the early signs of rachitic deformation and increased supervision by infant and toddler health bureaux, the reduction in the number of posture problems from the mid-1950s (see Table 3) is likely to be an effect of regular gymnastics and the introduction of school-based special gymnastics for children diagnosed with scoliosis or any

<sup>59</sup>SPG, GA no. 1236: II, 1–12.

<sup>60</sup>J.H. de Haas, *Kindersterfte in Nederland – Child Mortality in the Netherlands* (Assen: Van Gorcum, 1956), 66.

<sup>61</sup>De Beer, *Witte jassen*, 186.

<sup>62</sup>SPG, GA no. 1236: II, 1–12.

<sup>63</sup>De Beer, *Witte jassen*.

<sup>64</sup>*Verslag 1935*, 22.

<sup>65</sup>*De nieuwe school voor het lager onderwijs. Rapport van de Studiecommissie voor Scholenbouw, ingesteld door het Nederlands congres voor Openbare Gezondheidsregeling* ('s-Gravenhage: VNG, 1953).

<sup>66</sup>*Verslag 1940*; Van Setten, *In de school*.



other posture problem. Needless to say, school doctors became the selection authority for provision of this, which was largely paid for by the municipalities.

Throughout the 1950s we find pleas for more hours of gymnastics in the school curriculum, preferably one hour a day. In reality only one-and-a-half to two hours a week were prescribed.<sup>67</sup> These pleas went hand-in-hand with complaints about the quality of the accommodation where the lessons were taught: it was too small, too dirty or too dark. Some schools had to teach these lessons in the mud outside. From the early 1960s, however, these complaints fell silent, as villages and schools were accommodated with gymnasia. About 1960, school doctors ascribed an additional value to gymnastics as a means to enlarge the school's effectiveness. Children, they maintained, would learn more if they were physically healthy and energetic. Gymnastics would contribute to pupils' 'mental and physical' fitness and prevent moral 'degeneration'.<sup>68</sup> The same was true of outside playtimes: two instead of one were indicated in the morning. Young children especially would profit from the opportunity to move and run freely more often during the day.

From the 1930s, and particularly in the post-war years, a growing number of towns in the Province of Groningen could avail themselves of outdoor swimming pools. During the summer season swimming lessons were organised for the pupils in the middle grades of the primary schools. The art of swimming saved lives in a country full of ditches and channels and it promoted schoolchildren's positive health, both physical and mental, the school doctors claimed. Like other sports it could compensate for too many hours of intellectual work. Therefore, they immediately welcomed the initiative and hoped that these lessons would soon become available for all children in their districts. And, as expected, they took upon themselves the new assignment of obligatory examination of all candidates for the swimming lessons, focusing on children's ears, throat and heart.<sup>69</sup>

The examples of remedial gymnastics and swimming lessons show how the doctors themselves created part of their expanding assignment, about which they never stopped complaining in the 1950s and 1960s.<sup>70</sup> The example of continued tuberculosis screening of all pupils illustrates another paradox: increasing supervision in times of decreasing or even vanishing risk. As to numbers, it is clear that there is no clear-cut relationship between the abnormalities reported by the school doctors and children's physical ill-health. In certain respects there is even a reverse relationship, as more abnormalities sometimes coincide with improving overall physical health. The examples of sight, hearing and teeth illustrate that post-war increases in the numbers of abnormalities were sometimes 'produced' by improved or more frequent screening and by extension of medical care.

## Monitoring mental health

The Groningen school doctors' pleas for gymnastics and swimming illustrate how they succeeded in linking physical and mental health. From the early 1950s they paid tribute

<sup>67</sup>*Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1949* (Groningen: Hoitsema, n.d.), 50.

<sup>68</sup>*Verslag 1965*, 96.

<sup>69</sup>*Verslag 1949*, 23; *Verslag van de Schoolartsdienst in de groepen Appingedam, Bedum, Hoogezand-Sappemeer, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1959* (no place of publication, n.d.), 5–7.

<sup>70</sup>For example: *Verslag 1955*, 8.



**Table 4.** Average percentages of pupils fully examined by the school doctors in the Province of Groningen\* found to have mental abnormalities, according to their nature.<sup>a</sup>

Year and total number of districts	Bed-wetting	Speech	Backwardness**	Nervousness
1930: 2	3.5 (1)	–	–	–
1935: 4	3.0 (1)	1.4 (1)	–	–
1940: 3	1.6 (2)	1.5 (2)	1.7 (2)	–
1945: 6	4.2 (5)	0.9 (5)	2.3 (4)	–
1950: 7	3.8 (5)	1.3 (5)	2.5 (6)	0.8 (2)
1955: 7	5.5	3.8	3.1	6.7 (1)
1960: 9	6.2	4.8	2.4 (8)	8.9 (2)
1965: 9	6.2	3.2	1.4 (7)	–
1970: 9	6.5 (7)	3.4 (8)	2.2 (3)	–

\*Excluding the City of Groningen,;

\*\*Excluding the pupils of special schools.

Note: Figures in parentheses indicate number of districts providing information on this item (if lower than total).

<sup>a</sup>Sources: see Table 3.

to the new, positive and comprehensive concept of health. They conceived of their work as pivotal in promoting it. The first request for a child guidance clinic in the province was made by one of them in 1952.<sup>71</sup> However, as regards the periodic health examination, few new items concerning mental health were included in the list of items and it was certainly no matter of replacing a physical item with a mental one. These items concern bed-wetting, speech problems and mental retardation. As compared with the physical ailments, these illnesses and deficiencies were even more particularly concentrated with young children attending infant schools and the lower grades of primary schools. Therefore, the percentages of children suffering from mental health problems (Table 4) wrongly suggest that they occurred very infrequently. Secondary pupils, representing an even more rapidly increasing proportion of the children examined, were hardly ever diagnosed with these abnormalities.

Bed-wetting (*enuresis nocturna*) became a regular subject of examination from 1945. The increasing percentage of bed-wetting children (see Table 4) illustrates not so much a growing problem as the vanishing of a taboo. Mothers accompanying their child at the periodic health examination gradually lost their fear of talking about it and asked for a remedy. Although it was not discussed often, it is clear that the Groningen school doctors of the post-war years were aware of the complexity of the problem and of the possibility of a psycho-social background.<sup>72</sup> During the 1950s it was frequently called a 'neurotic disorder', a symptom of mental ill-health, or an effect of mental overburdening of a child.<sup>73</sup> Usually doctors differentiated between 'hereditary' mental weakness as cause of the trouble, which they associated with 'anti-social' families, and 'neurotic opposition' caused by parental faults.<sup>74</sup> One school doctor constructed a link between the large size of the school classes (up to 45 pupils), the uniformity of group teaching, and the ensuing weariness of the quicker pupils. The latter group was at risk of developing all kinds of nervous complaints, from enuresis to bad eating and behavioural problems, he explained.<sup>75</sup> The doctors agreed that enuresis was a hard-to-combat ailment, for which the right therapy had not yet been found. Only in very serious cases did doctors refer a bed-wetting child to the Youth Psychiatric Service.

<sup>71</sup>Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1952 (no place of publication, n.d.), 13, 38.

<sup>72</sup>Verslag 1949, 55.

<sup>73</sup>Verslag 1950, 66.

<sup>74</sup>Ibid., 63.

<sup>75</sup>Verslag 1958, 93.

Speech problems like stammering and stuttering – and later also lisping and hoarseness – were likewise systematically checked for from 1945. Referrals to speech therapy by trained professionals working for the district schools can be found from the early 1950s. Therefore, the relatively high percentage of speech-impaired children around 1960 (see Table 4) seems to be related first of all to the availability of speech therapists. This interpretation is supported by the simultaneous disappearance of complaints by school doctors concerning a lack of speech therapists in their districts. School doctors were aware of the possibility of a psychological background to speech problems, as they differentiated between impairments with and without an organic cause and classified almost all of them in the latter category. Some school doctors called stammering a neurotic disorder.<sup>76</sup> One was convinced of neuroticism ('a chronic conflict') as the cause of most cases of stammering and drew the conclusion that 'neurotic stammerers' would not profit from speech lessons as long as the 'inner tensions remained'. Treatment, therefore, had to be pedagogic or psychotherapeutic. On the basis of an investigation among heads of schools in one municipality, he estimated that 5–6% of the school population were victims.<sup>77</sup> In 1953 the provincial school doctors suggested that 8–10% of schoolchildren needed speech therapy.<sup>78</sup> They themselves would be responsible for selection.

*Nervositas* or nervousness was not systematically sought for by school doctors in the 1950s. It was not included in their list of items and was registered by only two provincial doctors (see Table 4). Others mentioned it as reason to send a child to a health colony or as an illness that could befall a child because of an overload of schoolwork or a lack of sleep because of stressful family circumstances.<sup>79</sup> In 1960 one school doctor estimated that some 30% of the pupils suffered from nervousness caused by 'psychological neglect'.<sup>80</sup> Homework for primary pupils was consistently warned against.<sup>81</sup> Young children needed to relax during their free hours. Lack of sleep was another constant complaint, which was first linked to parental incompetence and from the early 1960s to the new intruder in family life, the television.<sup>82</sup> In 1953 the provincial school doctors collectively expressed their worries about the large size of school classes by suggesting that mass teaching caused increasing 'emotional conflict' in children, 'neurotic reactions' and inhibitions, as well as mental overburdening.<sup>83</sup> Nevertheless, the numbers of referrals to the Youth Psychiatric Service and the 'medical advice bureau' because of nervousness always remained low, despite repeated statements during the 1950s like 'Behind every school medical service there must be child guidance'.<sup>84</sup> The 1960s brought both smaller classes and fewer complaints about nervousness and other emotional trouble, whereas learning disabilities were more often discussed.

Mental deficiency was the most important mental health issue for countryside school doctors of the 1950s and 1960s. Between 1939 and 1954 in the Province of Groningen every

<sup>76</sup>*Verslag 1950*, 66.

<sup>77</sup>*Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1951* (Groningen: Hoitsema, n.d.), 61.

<sup>78</sup>*Verslag 1953*, 5–8.

<sup>79</sup>*Verslag 1955*, 35.

<sup>80</sup>*Verslag 1960*, 85.

<sup>81</sup>For example: *Verslag van de Schoolartsdienst in de groepen Appingedam, Hoogezand, Veendam, Vlagtwedde, Winschoten, Winsum en Zuidhorn over het jaar 1956* (no place of publication, n.d.), 5–8.

<sup>82</sup>*Verslag 1963*, 5.

<sup>83</sup>*Verslag 1953*, 7.

<sup>84</sup>*Verslag 1952*, 38.

district centre established at least one special school for feeble-minded children, except for Bedum and Zuidhorn, towns near the City of Groningen with a railway station and a regular service. They continued to use the city's provisions. School doctors acted as crusaders in a campaign to fight parents' resistance to having a child attend a special school. They took pains to combat what they conceived of as the ignorance and prejudices of parents, such as the idea that children would not learn anything there, or that they would be better off in a classroom with children of normal intelligence.<sup>85</sup>

Throughout the period under study school doctors in Groningen, as elsewhere in the Netherlands, were responsible for the admission of pupils to a special school for feeble-minded children. As members of the admission authority they examined and, up to the 1960s, IQ-tested the candidates. IQ testing was done only upon a teacher's request, when a child had repeated a grade once or twice already and continued to be behind. Testing of whole school classes was not done regularly and IQ testing was not part of the periodic health examination either. Children qualified as 'backward' belonged at a special school according to their teachers, but could not attend one, usually because their district did not yet have one. Table 4 shows the percentages of 'backward' pupils who did not attend a special school. We have already seen that two districts in the far south and east of the province, Veendam and Winschoten, had relatively high percentages of pupils at such schools in 1970 (5.7% and 7.9% respectively). The Province of Groningen as a whole, however, had relatively low participation in special schooling of feeble-minded children: 1.3% of all primary pupils in 1950, as against 2% in the country as a whole. In 1962 in Veendam 5.2% and in Winschoten 3.6% of the primary pupils attended a school for feeble-minded children, as against 1.9% in the City of Groningen and 3% in the country as a whole.<sup>86</sup>

The rising percentage of these pupils is directly related to the increase in the number of special schools for mentally deficient children. In the Province of Groningen they increased from six with 689 pupils in 1950 to 11 with 1183 pupils in 1962.<sup>87</sup> The availability of a special school produced feeble-mindedness. School doctors turn out to have played a very active role in promoting special schooling and, consequently, in the high percentages of feeble-mindedness in particular towns. They blamed headmasters of village schools for keeping mentally deficient children in their schools out of fear of losing pupils.<sup>88</sup> The way they proceeded in advancing the establishment of a special school shows a distinct pattern. First, there were complaints about a state of emergency. Feeble-minded children were not accepted by an overcrowded special school in the City of Groningen. Second, an increasing number of children were IQ tested and found to be mentally deficient. Third, school doctors reported a high percentage of pupils with mental deficiencies and pressed for the establishment of a special school. In several cases, moreover, all pupils in the two lower grades of a number of schools in the district were IQ group-tested by the Youth Psychiatric Service. The percentage of these pupils found to be mentally deficient was presented as the estimated proportion of children in need of special schooling in their district, which could amount to 8% or 10%. Apparently, local authorities were easily convinced by these numbers. Each time this procedure was applied a special school was established within a few months. And

<sup>85</sup>*Verslag 1956*, 49; *Verslag 1963*, 120.

<sup>86</sup>*Statistiek van het buitengewoon lager onderwijs 1948/49–1950/51* (Utrecht: De Haan, 1951), 13; *Statistiek van het buitengewoon lager onderwijs 1958–1962* (Zeist: De Haan, 1964), 46–7.

<sup>87</sup>*Statistiek 1948/49–1950/51*, 13; *Statistiek 1958–1962*, 21–2.

<sup>88</sup>*Verslag 1955*, 15–16, 35; *Verslag 1956*, 49.

each time, in the year after a new special school had been established, the school doctor reported that it was flourishing and ‘provides for the needs of the district’.<sup>89</sup> School doctors’ complaints that parents did not understand the relevance of a special school for their child were repeated endlessly.<sup>90</sup>

Differentiation between classes or schools for only slightly mentally deficient children and pupils with a very low IQ score (below 50) proceeded along similar lines. One or two special schools in a district had to flourish before a school doctor could make this suggestion by complaining that the presence of the seriously learning-disabled ‘imbeciles’ had a negative influence on the parents’ willingness to have their feeble-minded child educated in the special school. The ‘imbeciles’ were said to chase away children who belonged in the special school. ‘Imbeciles’ were, moreover, said to be left without any instruction in the case of an overcrowded school for feeble-minded children. We see these arguments being used first in Winschoten in 1950 and three years later in Veendam, regional centres far away from the City of Groningen and without a railway connection.<sup>91</sup>

Although ‘partial defects’ or specific learning disabilities like dyslexia were recognised by school doctors in the Province of Groningen from the early 1950s,<sup>92</sup> the first LOM school for children with learning and behavioural problems in the province was not established until 1965 in Winschoten. The next one was established in Veendam only one year later.<sup>93</sup> This timing is probably due to the provincial school doctors’ collective plea to establish LOM schools in 1964, arguing that the province needed at least two of these.<sup>94</sup> This collective outburst of anger occurred after more than 10 years of lobbying by individual school doctors to have partial learning defects recognised as qualifying for special didactic support and as a mental health risk in case of continued disregard of these children’s educational needs.<sup>95</sup> Sometimes their lobbying was not rewarded until the 1970s, when LOM schooling grew quickly nationwide.<sup>96</sup>

## Conclusion

In spite of statements regarding the importance of mental health from the early 1950s and the overall improving physical health of pupils the school doctors in the Groningen countryside shifted their attention only to a limited extent from physical to mental health. They showed the same reluctance to do so as the profession as a whole, which preferred the traditional role of social-hygienic experts, leaving children’s minds largely to child psychiatrists and school psychologists. The Groningen school doctors continued to pay most of their attention to physical health and took upon themselves many related new tasks like tuberculosis screening of all pupils, the selection of candidates for special gymnastics, and the examination of all pupils who qualified for participation in school-organised swimming

<sup>89</sup>*Verslag 1945 en 1946*, 66–7, 93; *Verslag 1948*, 14–15, 23, 75; *Verslag 1949*, 23, 32–3; *Verslag 1950*, 105; *Verslag 1952*, 37; *Verslag 1958*, 82, 93.

<sup>90</sup>For example: *Verslag 1952*, 13; *Verslag 1953*, 76.

<sup>91</sup>*Verslag 1950*, 16–17, 96–7; *Verslag 1953*, 33.

<sup>92</sup>*Verslag 1953*, 33; *Verslag 1954*, 6.

<sup>93</sup>*Verslag 1965*, 101; *Verslag 1967*, 57.

<sup>94</sup>*Verslag 1964*, 5, 27, 71.

<sup>95</sup>The first proposal to establish a LOM school was made in 1953: *Verslag 1953*, 33. See also: *Verslag 1955*, 8; *Verslag 1956*, 5–7. In 1955 the school doctors estimated that 3–10% of primary pupils qualified for a LOM school.

<sup>96</sup>Graas, *Zorgenkinderen*, 114.

lessons. Their core activity, the periodic health examination of pupils, became much more extensive and detailed as regards aspects of physical health, but came to include only a few aspects of mental health, particularly bed-wetting, speech problems and backwardness. Nevertheless, mental health became important. In line with the new, WHO-inspired, positive and comprehensive concept of health, the school doctors actively stimulated activities they conceived of as promoting both physical and mental health, like gymnastics and swimming.

This case study shows that it was not a simple shift of focus. As regards mental health the school doctors' key interest was focused on mental deficiency and the promotion of special schooling for feeble-minded and learning-disabled children. In this respect they played a very active role, to the extent of producing feeble-mindedness and learning disabilities in the same way as the availability of speech therapy produced stammering and stuttering. This and the increase in abnormalities they found, particularly in the 1950s when children's physical health improved rapidly, as well as the increase in supervision in times of decreasing risk, provide a clear case of progressive, state-supported hygienic surveillance, disciplining and normalisation of childhood. At the same time, despite criticism of contemporary scientists, the school doctors clung not only to the tradition of searching for and counting abnormalities, but also to their ideal of supporting and promoting the school's effectiveness by trying to reduce possible dangers threatening what they conceived of as pupils' learning capacity and, increasingly, their mental well-being. The doctors' wish to make the school a safe place made them criticise not only the hygienic insufficiency of buildings and furniture, but also learning conditions like the large size of post-war school classes and uniform group teaching, as well as long hours of sitting still, as harmful to a child's mental well-being. The new professions of child psychiatrists and school psychologists tested and treated 'problem' children, but unlike the school doctors they did not get involved with the conditions of schooling in general. Child health, as it was monitored by the school doctors in this rural area, expanded. Increasingly, these doctors' activities and concerns reached beyond regulating schoolchildren's bodies.

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### Notes on contributor

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